If crime strikes you, WE CARE

Crime Victims CompensationProgram
Department of Labor & Industries
PO Box 44520
Olympia WA 98504-4520

www.wa.gov/lni/insurance/cvc.htm

1-800-762-3716 (toll free) or
360-902-5355
TDD users please call 360-902-4974
Interpreters available
Fax 360-902-5333

Application attached

Claim no:

F800-042-000 5-02 p1

Washington State

Crime Victims Compensation Program

Our Mission:

In partnership with the victim assistance community, we treat victims with dignity and respect while assisting in their recovery from the effects of violent crime.

Victim Assistance Groups

Office Of Crime Victims Advocacy
1-800-822-1067

Domestic Violence Hotline
1-800-562-6025

Washington Coalition Of Sexual Assault Program
1-360-754-7583

Family & Friends Of Violent Crime Victims
1-800-346-7555

Child Protective Services Hotline
1-800-562-5624

Victim/Witness Notification Program
1-800-322-2201

Mothers Against Drunk Driving
1-800-927-6080

Overcoming the physical injuries and emotional pain of a violent crime takes time - and it is harder to do when you face financial worries as well. The Crime Victims Compensation Program helps victims with costs related to crime injuries.

WHO CAN GET HELP?

- Victims injured in a violent crime in Washington State.
- Survivors of a homicide victim.
- Washington residents injured by an act of terrorism in a foreign country.

AM I ELIGIBLE?

Benefits cannot be paid to someone:

- Injured while participating in a felony.
- Injured while confined in jail, prison or institutionalized.
- Who incited, provoked or consented to the crime.
- Who is unwilling to provide reasonable cooperation to law enforcment

WHAT BENEFITS ARE AVAILABLE?

- Payment of medical, dental and mental health counseling bills.
- Partial payment of lost wages.
- Partial payment of funeral costs.
- Modification to homes and vehicles to accommodate permanent injuries.
- Limited pension payment if the crime prevents you from returning to work permanently.
- Limited pension payment to the spouse or child of a deceased victim.
- Counseling for family members of sexual assault victims and homicide victims.

All benefits listed have maximum dollar limits set by law. Property losses are not covered.

NOTE: You are not required to pay for an initial medical exam for sexual assault. However, you need to complete the attached application to receive benefits for further medical or mental health treatment.

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WHAT ARE THE REQUIREMENTS?

- Notify law enforcement of the crime within one year or within one year of when a report could have reasonably been made.
- CVCP must receive the application:
  - ~ Within two years of reporting the crime to law enforcement
  - ~ Within two years of your eighteenth birthday if you were a minor at the time of the crime
  - ~ Within five years from reporting the crime to law enforcement with good cause
- You need to use benefits available from all other public and private insurance first.
- You need to reimburse CVCP if you receive an insurance settlement or proceeds from a lawsuit based on the crime.

HOW DO I APPLY?

- Complete and **sign** the attached application.
- We will let you know in writing when we receive your application.
- We will contact you if we need more information.
- If you need assistance in completing this application, please call 1-800-762-3716.

Department of
LABOR and
INDUSTRIES

Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520
(360) 902-5355 or Toll Free 1-800-762-3716 Fax (360) 902-5333 TDD (360) 902-4974

APPLICATION FOR BENEFITS

Claim Number

Victim's name | SSN (for ID only) | M ☐ F ☐

Home address | City | State | ZIP

Mailing address (if different) | City | State | ZIP

Home phone ( ) | Message phone ( ) | Birth date / / | Date of Death (if applicable) / /

Victim's marital status
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed
- ☐ Divorced
- ☐ N/A(child victim)

Who referred you to our program?
- ☐ Attorney
- ☐ Police
- ☐ Victim/Witness Unit
- ☐ Prosecutor's Office
- ☐ Hospital
- ☐ Medical Provider
- ☐ Mental Health Provider
- ☐ Another victim
- ☐ Other:

What kind of benefits are you applying for? (mark all that apply)
- ☐ Medical/Dental
- ☐ Counseling/Mental Health Treatment
- ☐ Victim's loss of earnings (Time lost from work, must be verified by your medical/mental health provider)
- ☐ Funeral expenses
- ☐ Grief Counseling (for survivors of homicide victim(s))
- ☐ Loss of financial support (for dependents of homicide victim(s))

You are the:
- ☐ The Victim
- ☐ The Parent/Legal Guardian (of a child victim)
- ☐ The survivor of the deceased crime victim or beneficiary. (Provide address below-if different from address above)(attach copy of marriage certificate, children's birth certificate and proof of legal guardianship if children not living with their parent.)

Name of person making application (if different) | SSN (for ID only) | Relationship to victim

Mailing address (if different) | City | State | ZIP

Contact person's name (if you don't want us to call you at home) | Contact's Phone #

Each victim requiring assistance through our programs will need to fill out a separate APPLICATION.

This department collects and maintains information on claims by race, national origin and handicap for statistical purposes. If you object to furnishing this information, you may leave these questions blank.

Race or national origin: Black ☐ Pacific Islander ☐ White ☐ Asian ☐ Hispanic ☐ Native American ☐ Other ☐

Disabled Yes ☐ No ☐ Caused by crime: Yes ☐ No ☐

If English is not your primary language, what language do you speak? | Do you need an interpreter? Yes ☐ No ☐

Any relative, such as spouse or minor child(ren) who is/was financially dependent on the victim.

Name	Date of Birth	Relationship to Victim	Name	Date of Birth	Relationship to Victim
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

The crime injury must be reported to a police agency within 12 MONTHS of the incident OR within 12 MONTHS of when it could have reasonably been reported.

Date crime happened / / | Approximate time ☐ am ☐ pm | Was the crime reported to a police agency? ☐ Yes ☐ No | If yes, date crime reported / /

Location of crime: address

City | State | ZIP

Name of Enforcement Agency reported to: ☐ Police ☐ Sheriff ☐ WSP

Officer's name | Report Number

Is the victim related to the offender? ☐ Yes ☐ No If yes, relationship:

Was/is the offender living with you when the incident occurred? ☐ Yes ☐ No

Type of crime
- ☐ Assault
- ☐ Robbery
- ☐ Sexual assault (adult victim)
- ☐ Sexual assault (child Victim)
- ☐ Murder
- ☐ Domestic violence
- ☐ Vehicular assault
- ☐ DUI vehicular crime
- ☐ Vehicular homicide
- ☐ Other _____
- ☐ Civil commitment of a sexual predator. Date you were contacted about proceedings / /

Weapon used _____

Area of body injured _____

Contacted by: (Name) | Contact's Phone #: ( )

Brief description of the crime:

Offender(s) name (if known)
1. 2.

Have you filed or do you intend to file a civil law suit? ☐ Yes ☐ No

Your provider must bill your primary insurance first

All insurance resources must be listed. This includes, welfare, health, auto (victim & offender's), life, workers comp., etc. Crime Victims Section can only pay benefits after your insurance(s) have paid all they will pay on your claim.

- ☐ Health
- ☐ Dental
- ☐ Medicare
- ☐ SSI/SSA
- ☐ Indian Health
- ☐ Public Assistance (Medicaid)
- ☐ Victims Auto (answer only if this was a vehicular crime)
- ☐ Offenders Auto (answer only if this was a vehicular crime)
- ☐ Other (Life, Burial Benefits, etc.)
- ☐ No Insurance

Insurance company name	Effective date	Ending date	Name of Policy Holder	Policy Number
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		

Is the victim a union member? ☐ Yes ☐ No if yes, what union? Union membership number:

Time lost from work due to your injury must be verified by your medical/mental health provider. Have you (the victim) lost time from work because of this incident? ☐ Yes ☐ No Were you (the victim) employed at the date of the crime? ☐ Yes ☐ No
OR were you (the victim) employed for 3 consecutive months during the 12 months prior to this crime? ☐ Yes ☐ No

Was your employer providing you and/or family with medical, dental or vision insurance on the day you were injured? ☐ Yes ☐ No

Employer Phone number

Address City State ZIP

RESOURCES

What is/was the monthly income of the victims' household? (Check one)

- ☐ From $000.00 but less than $527.00
- ☐ From $527.00 but less than $592.00
- ☐ From $592.00 but less than $667.00
- ☐ From $667.00 but less than $742.00
- ☐ From $742.00 but less than $858.00
- ☐ From $858.00 but less than $975.00
- ☐ $975.00 or more

How many people in the victim's household are/were financially dependent on th[illegible]?

A determination cannot be made on your claim until we have received the required information and your signature.

I understand that if I receive any recovery of my losses through court-imposed restitution or civil lawsuit against the offender, any insurance settlement, or moneys from any other government or private agency, I shall reimburse the State of Washington Crime Victims Compensation Program for any compensation paid out under this claim.

I hereby authorize any hospital, physician or other person who attended or examined (name of victim)_____: any funeral director or other person who provided services; any employer of the victim; any law enforcement agency or other government agency, including state and federal services; any insurance company or any other agency having knowledge necessary for the determination of eligibility on this claim for benefits to furnish to the Crime Victims Compensation Program or its representatives any and all information specifically pertaining to this claim. Other information may be required to determine whether conditions are related to the crime. I understand this may include results of HIV and other sexually transmitted disease testing, alcohol and drug treatment.

Remember to sign and date this form

Date / / Printed name of victim, parent, legal guardian or beneficiary

Written signature of victim, parent, legal guardian or beneficiary

Please have your physician or practitioner fill out this section if you have received medical treatment for this injury

Victim's name Date of Injury Date you first treated patient for this injury

Physician's name Phone number

Name of medical facility Phone number

Address City State ZIP

Diagnosis: Description of Injury: (please include area of body injured) Physician's signature

If counseling or mental health treatment applies, please fill out the following information.

Have you had counseling due to this incident? ☐ Yes ☐ No If yes, which counselor did you see?

(If you have not seen a counselor but intend to seek counseling, please provide the name and telephone of the counselor you intend to see.)

Name Phone Number

Address City State ZIP